

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
08528 CERTIFICATE OF DEATH

Reg. Dist. No.

08532

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRELLIN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR</b>		First <b>LYNN</b>	Middle <b>BOWMAN</b>
4. DATE OF DEATH <b>AUGUST 11, 1957</b>		Month <b>AUGUST</b>	Day <b>11</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>8/10/57</b>		9. AGE (In years lost birthday) yrs. <b>40</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE EDWARD BOWMAN, JR.</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA MAY HOSE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>CLARENCE EDWARD BOWMAN, JR., CRELLIN, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>527.2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 Aug., 1957</b> to <b>11 Aug., 1957</b> that I last saw the deceased alive on <b>11 Aug., 1957</b> , and that death occurred at <b>10:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. E. Mance</b>		ADDRESS (Street, city or town, state) <b>Oakland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE, M.D.</b>		DATE SIGNED <b>12 Aug. 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 14, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ashby Cemetery</b>		22d. LOCATION (City, town, or county) <b>Crellin, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. R. Watson</b>		24a. REC'D BY REGISTRAR <b>8/14/57</b>	
ADDRESS <b>Terra Alta, W.Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Julie Mance</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASH. D. C.

BUREAU V. S.

AUG 27 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08529 CERTIFICATE OF DEATH

Reg. Dist. No. 08533

1. PLACE OF DEATH o. COUNTY <b>Garrett County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accident</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Watercliffe Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		First <b>Graham</b>	Middle <b>Boyd</b>
4. DATE OF DEATH <b>Aug, 14th. 1957</b>	Month <b>1957</b>	Day <b>14</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 19th, 1874</b>
9. AGE (In years last birthday) <b>83</b>	10. IF UNDER 1 YEAR Months <b>83</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>	14. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, MD.</b>	15. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>	16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
17. FATHER'S NAME <b>John M. Boyd</b>	18. MOTHER'S MAIDEN NAME <b>Mary Ann Spears</b>	Address	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	20. SOCIAL SECURITY NO. <b>NONE</b>	21. INFORMANT <b>Mrs. Melvin Kesner, Accident, MD.</b>	
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>(b)</b>		<b>Coronary Artery Heart Disease</b>	
DUE TO <b>(c)</b>		<b>I Left Ventricular Failure</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
23. POSSIBLE GASTROINTESTINAL HEMORRHAGE		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>1. Injury occurred at 8/14/57, 1957, at 12:00 AM, from the causes and on the date stated above.</b>		
27. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	28. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>48 BROADWAY</b>	(County) <b>FROSTBURG, MD.</b>
30. I certify that I attended the deceased from <b>8/12/57, 1957</b> to <b>8/14/57, 1957</b> , that I last saw the deceased alive on <b>8/14/57, 1957</b> , and that death occurred at <b>12:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 BROADWAY</b>		DATE SIGNED <b>8/14/57</b>	
31. ACTUAL SIGNATURE <b>Martin M. Rothstein, M.D.</b>	32. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN, M.D.</b>		
33. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	34. DATE THEREOF <b>Aug, 16, 1957</b>	35. NAME OF CEMETERY OR CREMATORIAL <b>Oak Hill Cemetery</b>	36. LOCATION (City, town, or county) <b>LONACONING, MD.</b>
37. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN, LONACONING, MD.</b>	38. ADDRESS <b>GEORGE EICHORN, LONACONING, MD.</b>	39. RECEIVED BY REGISTRAR DATE <b>AUG 27 '57</b>	40. REGISTRAR'S SIGNATURE <b>Alfred</b>

DEPARTMENT OF HEALTH - BALTIMORE CITY  
CITY OF BALTIMORE - STATE OF MARYLAND

CEMETERY - STATE OF MARYLAND

BUREAU V. S.  
AUG 27 1957  
RECEIVED

RECEIVED

AUG 19 1957

GARRETT COUNTY  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**08530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08534  
 166

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>W. VA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TERRA ALTA</b> 85x-3	
d. STREET ADDRESS <b>127 4</b>		d. DATE OF DEATH Month <b>AUGUST</b> Day <b>3</b> Year <b>1957</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EARL</b>		First <b>LESLIE</b>	Middle <b>FREELAND</b>
4. DATE OF DEATH Month <b>AUGUST</b> Day <b>3</b> Year <b>1957</b>		5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr 4-1885</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <b>W. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. FREELAND</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH BRAHAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>934-32-8195</b>	
17. INFORMANT <b>WARDEN FREELAND - Youngstown</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CROSTING INJURIES FACE, SKULL &amp; CHEST</b>	
DUE TO <b>802x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>	
DUE TO (b) <b>WITH RUPTURED LUNGS</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture rt knee - Left ankle</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>STRUCK by RR. LOCOMOTIVE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7:15</b> p. m. <b>8/3 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RR. CROSING - OAKLAND GARRET</b>
20f. (City or town) <b>OAKLAND GARRET</b>		(County) <b>M</b>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED <b>8/6/57</b>	
ACTUAL SIGNATURE <b>E. I. BAUMGARTNER</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. I. BAUMGARTNER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/6/57</b>		22b. DATE THEREOF <b>8/6/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>TERRA ALTA</b>		22d. LOCATION (City, town, or county) <b>OAKLAND GARRET</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emerson Holden Oakland Md</b>		ADDRESS <b>127 4</b>	24a. REC'D BY REGISTRAR <b>8/6/57</b>
			24b. REGISTRAR'S SIGNATURE <b>Julia Kavanagh</b>

RECEIVED  
BUREAU V. S.

AUG 14 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08535

08531

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Route		c. LENGTH OF STAY IN 1b 8 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Happy Hills Farm		e. STREET ADDRESS 29 Frostburg Ave.	
3. NAME OF DECEASED (Type or print) JACOB		First HAFER	Middle Last Month Day Year 8 8 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 22, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture & Funeral		10b. KIND OF BUSINESS OR INDUSTRY Own business	11. BIRTHPLACE (State or foreign country) New Morchen, Germany
13. FATHER'S NAME Jacob Hafer		14. MOTHER'S MAIDEN NAME Elizabeth Berg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Frank A. Mattingly, Frostburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH arterio-sclerotic cardio - vascular disease 5 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-15-50, 1957, to 8-8, 1957, that I last saw the deceased alive on 8-2, 1957, and that death occurred at 691 M, from the causes and on the date stated above.		ADDRESS (Street, City or town, state) M.D. 39th Main St. Frostburg, Md.	
ACTUAL SIGNATURE H.C. Diehl		DATE SIGNED 8-9-57	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-57	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park Frostburg
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR S-9-57	24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08536

166

08532

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL OR and nearest town TOWN <b>Oakland</b> )		MARYLAND LENGTH OF STAY (In this place) <b>6WKS</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Kitzmiller</b>		Garrett COUNTY	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Evans Nursing Home</b>		STREET ADDRESS <b>1 W. Main Street</b>		(If rural give location)			
3. NAME OF DECEASED (First) <b>Edward</b> (Middle) <b>Jackson</b> (Last) <b>Hamill</b>				4. DATE OF DEATH <b>August 25</b>		(Month) (Day) (Year) <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR <b>White</b>	7. SINGLE, MARRIED, WIDOWED - DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>August 8, 1865</b>	9. AGE last birthday <b>92</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired - Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Kitzmiller, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Hamill</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ann Fazenbaker</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> unk.)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Gladys B. Hamill - Kitzmiller, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
18. MEDICAL CERTIFICATION  I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>442X IMMEDIATE CAUSE</b> (A) <i>Acute myocardial infarction</i> ANTECEDENT CAUSE(S) DUE TO <i>chronic cardiac - vascular disease</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Chronic</i> GIVING RISE TO THE ABOVE CAUSE DUE TO <i>cardio-vascular disease</i> STATING UNDERLYING CAUSE LAST. (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hyperactive left foot</i>  19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION <i>None</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <i>Kitzmiller</i> (State) <i>Md.</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) <b>Aug.</b> (Day) <b>25</b> (Year) <b>1957</b> (Hour) <b>4:45 A.M.</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>E.S.T.</i>			
22. I hereby certify that I attended the deceased from <b>Aug. 24, 1957</b> , to <b>Aug. 25, 1957</b> , that I last saw the deceased alive on <b>Aug. 24, 1957</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above. SIGNATURE <i>Ralph Colandelle</i> M.D. ADDRESS (Street, city, town, state) <i>Kitzmiller, Md.</i> DATE SIGNED <b>Aug 26-57</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 28/57</b>		NAME OF CEMETERY OR CREMATORIUM <b>Hamill Cemetery</b>		LOCATION (City, town, or county) <b>Kitzmiller, Md.</b> (State) <b>W.Va.</b>	
24. REG'D BY REGISTRAR <b>12657</b>		REGISTRAR'S SIGNATURE <i>James Rowan</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>O. F. Sharpleas</i>		ADDRESS <b>Blaine, W.Va.</b>	
DATE							

RECEIVED  
BUREAU V. S.

AUG 28 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08537

## 08533 CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin, Maryland	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Iva	Middle Harrett
Last Hayes		4. DATE OF DEATH August	Month 24,
5. SEX Female		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 13, 1888		9. AGE (In years last birthday) 89 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tunnelton, West Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Newton Michaels		14. MOTHER'S MAIDEN NAME Sara Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT J. W. Hayes, Address Crellin, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 40-100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>16 April, 1959</u> to <u>24 Aug, 1957</u> , that I last saw the deceased alive on <u>24 Aug, 1957</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Oakland, Maryland.			
ACTUAL SIGNATURE <i>Andrew E. Mance</i>		DATE SIGNED 25 Aug 57	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Aug. 27, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Shay's Chapel Cemetery	
22d. LOCATION (City, town, or county) Tunnelton, West Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. R. Watson</i>		24a. REG'D BY REGISTRAR DATE 8/24/57	24b. REGISTRAR'S SIGNATURE <i>Julia M. Powers</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECEIVED  
AUG 28 1957

REAU V. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this autopsy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed, it should be detained for us as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08538

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

08534

## 1. PLACE OF DEATH

COUNTY	GARRETT		MARYLAND	STATE	Md		COUNTY	GARRETT	
CITY (If outside corporate limits, write RURAL or and give nearest town)			LENGTH OF STAY (In this place)	LIFE		CITY (If outside corporate limits, write RURAL, and give nearest town)			
TOWN	RURAL ACCIDENT			no		TOWN	RURAL ACCIDENT		
HOSPITAL OR INSTITUTION OR STREET ADDRESS				1		STREET ADDRESS			

## 3. NAME OF DECEASED (First) (Middle) (Last)

JOHN CALVIN HETRICK

4. DATE (Month) (Day) (Year)

AUG 5 1957

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

MARRIED

8. DATE OF BIRTH

APRIL 6 1877

9. AGE last birthday

80 yrs

IF UNDER 1 YEAR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

OWN FARM

11. BIRTHPLACE (State or foreign country)

GARRETT Co

12. CITIZEN OF WHAT COUNTRY

Md

13. FATHER'S NAME

JOHN C HETRICK

14. MOTHER'S MAIDEN NAME

LAURA KINNET

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Rolando Hetrick, Accident Mdg

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4. IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST, DUE TO

(C)

5. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21a. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21b. TIME OF INJURY (Month) (Day) (Year) (Hour) 21c. INJURY OCCURRED (While at work) (Not while at work)

21d. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from (Date) to (Date), that I last saw the deceased alive on (Date), and that death occurred at (Time), from the causes and on the date stated above.

SIGNATURE (Street, city, town, state) DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)

24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

DATE

W. V. MURRAY

1900-1901

1900-1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08535

08535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

085396  
Dist. No.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		(Near) Oakland		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Allegany				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frostburg				
3. NAME OR DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Male		Eugene	Clement	Jeffries	Aug. 25th. 1957		19			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1YEAR	11. IF UNDER 24 HRS.			
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 5th. 1936	21	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Truck Driver				Frostburg, MD.		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Clement Jeffries		Margaret McKenzie		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT						
No		214-34-1780		Mrs. Eugene Jeffries, Frostburg, MD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									19. WAS AUTOPSY PERFORMED?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Drowning							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH Instant	
(b)										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED?	
20c. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Boat Capsized and Sunken.										
20c. TIME OF INJURY Month, Day, Year Hour 10:30 a.m. 8.25 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
				F. LAKE		Nr. OAKLAND		Garrett	MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting								DATE SIGNED 8.25.57
22a. BURIAL, CREMATION, REMOVAL (If applicable)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)		
Burial		Aug. 28. 1957		Memorial Park		Frostburg, MD.				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
George Eichhorn		Lonaconing, MD.		8/28/57		John R. Kip				

REFUGEE VIEO  
BUREAU  
GARIBOLDI  
HEALTH COUNSELOR  
SEP 1957  
1150  
REFUGEE VIEO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08540

08536

## CERTIFICATE OF DEATH

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. LENGTH OF STAY IN 1b 2 Months		b. COUNTY Garrett					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kiscr Nursing Home			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Friendsville						
3. NAME OF DECEASED (Type or print) Ada Vernon Leighton			4. DATE OF DEATH August 20, 1957						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>					
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17, 1874					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY for others		9. AGE (In years last birthday) 82 yrs					
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Isaa c Leighton					
14. MOTHER'S MAIDEN NAME Elizabeth Vernon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----					
17. INFORMANT Grace Falkenstein		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Hypertension Arteriosclerosis CVD with 8 years Hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 may, 1953, to 20 Aug., 1957, that I last saw the deceased alive on 16 Aug., 1957, and that death occurred at 8:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE A. E. Mance		ADDRESS (Street, city or town, state) 101 Third St., Oakland, Md.		DATE SIGNED 22 Aug. 57					
PHYSICIAN'S NAME (Type) A. E. Mance, M. D.		22d. LOCATION (City, town, or county) Oakland, Md.		(State)					
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 8/22/1957		22g. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery					
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.		24a. SIGNED BY REGISTRAR DATE 8/22/57					
				24b. REGISTRAR'S SIGNATURE Julia E. Koway					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUNEAU V. S.

AUG 27 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08537

## CERTIFICATE OF DEATH

08541  
166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle I Last LEWIS.		4. DATE OF DEATH Month AUG - Day 6 Year 1957	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov - 20 - 1892	
9. AGE (In years from birthdate) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) SWALLOW FALLS MD		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAREL SPIKER		14. MOTHER'S MAIDEN NAME JENNY SINES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT RICHARD A. LEWIS RE: OAKLAND MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i>		19. INTERVAL BETWEEN ONSET AND DEATH 2 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular disease</i>		20. DUE TO <i>Senile</i> 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6 Nov., 1948</i> to <i>6 Aug., 1957</i> that I last saw the deceased alive on <i>2 August, 1957</i> , and that death occurred at <i>5301</i> M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. E. Phane M.D.</i> M.D. ADDRESS (Street, city or town, state) <i>Oakland Md</i> DATE SIGNED <i>8 Aug '57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG - 9 - 1957	
22c. NAME OF CEMETERY OR CREMATORY SINES CEMETERY		22d. LOCATION (City, town, or county) NEAR OAKLAND MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Emroy Golden</i>		24a. REC'D. BY REGISTRAR <i>1957</i> <i>Julie Mowen</i>	
ADDRESS <i>OAKLAND MD</i>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

AUG 14 1957

REGISTRATION

TO **MEDICAL DIRECTOR:** This certificate should be **exhibited** within 24 hours after death. If any delay is necessary, please **exhibit** the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your **reference** or **removal**.

VS. ATSMC(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08538 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 108542  
66

1. PLACE OF DEATH a. COUNTY GARRETT			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) i. RURAL FRIENDSVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL			d. STREET ADDRESS ROUTE #1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First RANDALL	Middle EUGENE	Last LOWDERMILK	4. DATE OF DEATH AUGUST 14 1957	Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/8/39	9. AGE (In years last birthday) 17 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Fathers Farm		11. BIRTHPLACE (State or foreign country) FRIENDSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ROBERT E. LOWDERMILK			14. MOTHER'S MAIDEN NAME AMANDA VAN SICKLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT R. E. Lowdermilk R. D. Friendsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub dural Hemorrhage DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage DUE TO: Cerebral hemorrhage (c) Auto accident DUE TO: Auto accident						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Automobile turned over			
20c. TIME OF INJURY Hour o. m. 3:15		Month, Day, Year 8/11 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sick bed near Friendsville Garage	20f. (City or town) Friendsville	(County) (State) Howard Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> Signature: E. I. Baumgartner						
ACTUAL SIGNATURE E. I. Baumgartner		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		8/15/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/1957		22c. NAME OF CEMETERY OR CREMATORIUM Blooming Rose Cemetery		22d. LOCATION (City, town, or county) Near Friendsville, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.		24a. REC'D. BY REGISTRAR 8/15/57		24b. REGISTRAR'S SIGNATURE H. C. Leighton

RAU V.

1957 15

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08539

## CERTIFICATE OF DEATH

Reg. Dist. No.

085436

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Anna	Middle Ples	Last Mance	4. DATE OF DEATH	Month Aug.	Day 5	Year 19 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1882	9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Croatia, Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mija Ples		14. MOTHER'S MAIDEN NAME Barbara Yakin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Dr. A. E. Mance, Oakland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Hypertonic Encephalitis</i>		INTERVAL BETWEEN ONSET AND DEATH 4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO <i>arteriosclerotic Embolus</i>		2 1/2 yrs			
(c) DUE TO <i>Pericarditis</i>		<i>Arteriosclerotic Embolus</i>		10 yrs			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Oakland	(County) (State)
21. I certify that I attended the deceased from _____, 1955, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, 9:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>A. E. Mance</i> ADDRESS (Street, city or town, state) M.D. <i>Oakland, Md.</i> DATE SIGNED <i>8 Aug '57</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/57	22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest Boiden</i>		ADDRESS Oakland, Md.		24a. REC'D. BY REGISTRAR DATE 8/7/57		24b. REGISTRAR'S SIGNATURE <i>Julia M. Brown</i> ER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

AUG 12 1957

REGELV

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08540

## CERTIFICATE OF DEATH

08544

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WEEKS NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>TACY</b>		First	Middle
4. DATE OF DEATH <b>Acc.</b>		Month	Day
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>JULY-5-1872</b>		9. AGE (in years from birth) <b>85</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WILMINGTON OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ABE. WALKER.</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE PATTERSON.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MRS. WILSON K. LEUERING JR.</b>		Address <b>4302 ROLAND AVE. BALTIMORE MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO 35X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of R. Femur - 1956</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <b>19</b> Not while p. m. <input type="checkbox"/> of work <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 5, 1956</b> to <b>August 10, 1957</b> that I last saw the deceased alive on <b>July 10, 1957</b> , and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Baumgartner</b>		ADDRESS (Street, city or town, state) <b>25 Alder St Oakland Md</b>	
PHYSICIAN'S NAME (Type) <b>E. Baumgartner</b>		DATE SIGNED <b>8/10/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG-12-1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>SUGAR GROVE CEMETERY</b>		22d. LOCATION (City, town, or county) <b>WILMINGTON OHIO.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		ADDRESS <b>OAKLAND MD</b>	
24a. RECEIVED BY REGISTRAR <b>8/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Julia O'Nolan</b>	

RECEIVED  
BUREAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08541

## CERTIFICATE OF DEATH

085456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 16 <b>5 HRS. 15 MIN.</b> X / RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FANNIE</b>	First <b>FANNIE</b>	Middle <b>Elliott</b>	Last <b>SMOUSE</b>
4. DATE OF DEATH <b>AUGUST 12 1957</b>	Month <b>AUGUST</b>	Day <b>12</b>	Year <b>1957</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 20, 1888</b>
9. AGE (In years last birthday) <b>69 yrs</b>		10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS. <b>Days</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>ADAM ELLIOTT</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA PAUGH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>	17. INFORMANT <b>DANIEL SMOUSE</b>
		Address <b>ROUTE 2, OAKLAND, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Arteriosclerotic heart disease</b>			
DUE TO (c) <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>Aug.</b>	Day <b>12</b>	Year <b>1957</b>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>58 2nd St. Oakland, Md.</b>	20f. (City or town) <b>OAKLAND</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>July 20, 1957</b> to <b>Aug. 12, 1957</b> , that I last saw the deceased alive on <b>July 20, 1957</b> , and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>JAMES H. FEASTER, JR.</b>		ADDRESS (Street, city or town, state) <b>OAKLAND, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR. M. D.</b>		DATE SIGNED <b>Aug. 13, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/15/1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Oakland Cemetery</b>	22d. LOCATION (City, town, or county) <b>Oakland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D. BY REGISTRAR <b>4/13/57</b>		24b. REGISTRAR'S SIGNATURE <b>4/13/57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

106

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08542 CERTIFICATE OF DEATH

08546

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEER PARK</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <b>DEER PARK.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOWSER NURSING HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <b>DEER PARK.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH</b>		First <b>SILAS</b>	Middle <b>TEETS</b>
4. DATE OF DEATH <b>AUG 25 1957</b>		Lost <b>76</b>	Month Year Day Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>JUNE-13-1881</b>		9. AGE (In years lost birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACKSMITH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ACCIDENT</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>SILAS TEETS.</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH SHOYER.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>230-03-7288</b>	
17. INFORMANT <b>SOSIE TEETS</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Acute Myocardial suffusion</b> 3 days	
		(b) <b>Cerebral Hemorrhage with its fatal paroxysm</b> 5 days	
		(c) <b>Chronic Coronic Vascular and Debris</b> 2 yrs	
19. MEDICAL CERTIFICATION		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 24 1957</b> to <b>Aug 25 1957</b> , that I last saw the deceased alive on <b>Aug 24 1957</b> , and that death occurred at <b>3:50 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Ralph C. Sandrell</b> M.D. ADDRESS (Street, city or town, state) <b>Kitts Landing, Md.</b> DATE SIGNED <b>Aug 27-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG-28-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GEORGE CEMETERY</b>		22d. LOCATION (City, town, or county) <b>NEAR SWANTON, MD.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		24a. REC'D BY REGISTRAR DATE	
ADDRESS <b>OAKLAND MD</b>		24b. REGISTRAR'S SIGNATURE	

RECEIVE

SEP 5 1967

BUREAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08547  
166

08543

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Oakland		c. LENGTH OF STAY IN 1b 18 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEEK's Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) ALVINA		d. STREET ADDRESS 814 Camden Ave.	
3. NAME OF DECEASED (Type or print) ALVINA		First	Middle
4. DATE OF DEATH TEUFEL		Month 8	Day 13
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1869	
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Baltimore, Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Brandt		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harry D. Schmidt		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Degenerative Cardiovascular Disease (c)	
19. INTERVAL BETWEEN ONSET AND DEATH 24 hr		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Generalized bodily debility	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Aug. 12, 1957, to Aug. 13, 1957	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 770 Oak Street		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 12, 1957</u> to <u>Aug. 13, 1957</u> that I last saw the deceased alive on <u>Aug. 12, 1957</u> , and that death occurred at <u>6:14 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type) Garrett H. Lightfoot, M.D.		21. ADDRESS (Street, city or town, state) 770 Oak Street Oakland, Maryland DATE SIGNED 13 Aug 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 15, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Western Cemetery		22d. LOCATION (City, town or county) Baltimore (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 8/14/57	
24b. REGISTRAR'S SIGNATURE Julia C. Rowan JCR			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director  
page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFEVIEW

ALG

REAU V. S

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										085486 6	
08544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>			c. LENGTH OF STAY IN 1b <b>3 weeks</b>		b. COUNTY <b>DISTRICT OF COLUMBIA</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 47X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>1217 13th STREET N.W.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JESSIE CONNEWAY</b>		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b> <i>Aug 18. 1884</i>	9. AGE (in years less birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Int. Rev. Serv U.S. Government</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		
13. FATHER'S NAME <b>CONNEWAY, DAVID L.</b>					14. MOTHER'S MAIDEN NAME <b>ASHBY, DOXXOXX ELIZA JANE</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. J. A. Duffy</b>			Address <b>Oakland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>823X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Fracture Lefthand - Accidion Lefthand</b>										INTERVAL BETWEEN ONSET AND DEATH <b>18 m</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture Mandible - Fracture 6, 7, 8, 9 Ribs</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Automobile accident - Ran over on hand</b>								
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m. <b>July 16 1957</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State road near Kitzmiller Garrett Md</b>			20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <b>J. D. Baumgartner</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/18/57</b>									
EXAMINER'S NAME (Type) <b>E. T. BAUMGARTNER M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. RECD BY REGISTRAR DATE <b>8/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Jessie Conneway</b>					

BUREAU V. S

AUG 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08545 CERTIFICATE OF DEATH

08549  
766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 131 Front St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home									
3. NAME OF DECEASED (Type or print)	First Marie	Middle Bridgett	Last Williams	4. DATE OF DEATH Aug	Month Aug	Day 30	Year 1957		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 3, 1881	9. AGE (In years from birthday) 75	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Luke Kearney				14. MOTHER'S MAIDEN NAME not known					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Joseph Taylor-Westernport, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis and Myocardiol</i> DUE TO <i>422.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Piedmont, W. Va.	20f. (City or town) Piedmont, W. Va.	(County) W. Va.	(State) W. Va.
21. I certify that I attended the deceased from Aug. 27, 1957, to Aug. 30, 1957, that I last saw the deceased alive on Aug. 29, 1957, and that death occurred at 410 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED 8-31-57									
ACTUAL SIGNATURE <i>Paul A. Wilson</i>		M.D.							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/3/57	22c. NAME OF CEMETERY OR CREMATORIY St. Peters Cem		22d. LOCATION (City, town, or county) Westernport		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>El. Burial</i>		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR 9/3/57		24b. REGISTRAR'S SIGNATURE <i>El. Burial</i>			

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. SAVINAGE	65	MALE	HEART DISEASE
ADDRESS	AGE AT DEATH	TIME OF DEATH	TIME OF DEATH
1000 BROADWAY	65	10:00 P.M.	10:00 P.M.
ST. LOUIS, MO.	65	10:00 P.M.	10:00 P.M.
DEATH CERTIFICATE NO.	ISSUED BY	ISSUED AT	ISSUED ON
100-123456	CLERK OF DEPT. OF	ST. LOUIS, MO.	SEP 5 1957

BUREAU V. S

SEP 5 1957

RECEIVED